Filing at a Glance

Company:	New York Life Insurance Company
Product Name:	2013 NB21 EWL Application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/11/2012
SERFF Tr Num:	NYLC-128681039
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	213-555
Implementation Date Requested:	
Author(s):	Linda Lopinto, Robert Williams III, Ariana Castillo, Wanda Santos-Colletti, Barbara Micek
Reviewer(s):	Linda Bird (primary)
Disposition Date:	09/14/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: 2013 NB21 EWL Application
Project Number: 213-555
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type:
Filing Status Changed: 09/14/2012
State Status Changed: 09/14/2012
Created By: Robert Williams III
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Robert Williams III

Filing Description:

Re: New York Life Insurance Company (NYLIC)
Part I Application Form 213-555
Replacing Form 212-555, Approved on 3/13/2012, Tr. Num: NYLC-128159260
To Be Used With Policy Form 207-52.49, Approved on 08/31/2006,
Tr: Num: USPH-6SYPAD756/00
NAIC #: 82666915
FEIN #: 13-5582869

Dear Commissioner:

We are enclosing for your Department's approval a new application, form 213-555, for use when applying for the Employee's Whole Life product. This application will replace application form 212-555 which was approved by your department on 3/13/2012, Tr. Num: NYLC-128159260. We expect to introduce this new application in January 2013, or as soon thereafter as administratively possible.

The Employee's Whole Life Insurance Application Form 213-555 will be used to apply for our Employee's Whole Life Insurance policy, form 207-52.49, which was approved by your Department on August 31, 2006, Tr. Num: USPH-6SYPAD756/00, and will be issued on either a guaranteed issue or simplified issue basis.

Replacement questions are included in a separate form "Important Notice: Replacement of Life Insurance or Annuities", form 22190.100 which was approved by your Department on 9/13/2007, under Tr. Num: NYLC-125284281. Both the applicant and the agent must sign this form, and it is required that one copy be left with the applicant and another copy be submitted with every Part I application. A Part I application will not be processed without a signed Replacement form.

This new application has been assigned a new form number and has been modified in order to achieve consistency across all of our applications. The text of this revised application is substantially similar to our previously approved application by your Department, and has been slightly modified to ensure our continuing compliance with the Arkansas Insurance Department.

This application will be used in paper. The PDF submitted is the typeset version that will be printed by an outside vendor and stocked for use. They will also be made available on the company intranet for printing by the agents on their personal computers.

Additional Enclosures

- A readability certification applicable to the enclosed application form
- Application

We would appreciate receiving your Department's approval of the enclosed forms, at your earliest convenience. If there are any questions regarding this filing, you may call me toll free at 1-877-464-0198 or email me at Linda_E._LoPinto@newyorklife.com.

Sincerely,
Linda E. LoPinto
Corporate Vice President

Company and Contact

Filing Contact Information

Robert Williams III, Contract Consultant
51 Madison Avenue
Room 0154
New York, NY 10010

Robert_Williams_III@nyl.com
212-576-3449 [Phone]
212-447-4141 [FAX]

Filing Company Information

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
(212) 576-4809 ext. [Phone]

CoCode: 66915
Group Code: 826
Group Name:
FEIN Number: 13-5582869

State of Domicile: New York
Company Type: Life
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

Company	Amount	Date Processed	Transaction #
New York Life Insurance Company	$50.00	09/11/2012	62577636

SERFF Tracking #:	*NYLC-128681039*	***State Tracking #:***		***Company Tracking #:***	*213-555*

State:	*Arkansas*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*2013 NB21 EWL Application*		
Project Name/Number:	*2013 NB21 EWL Application/213-555*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/14/2012	09/14/2012

SERFF Tracking #:	*NYLC-128681039*	***State Tracking #:***		***Company Tracking #:***	*213-555*

State:	*Arkansas*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*2013 NB21 EWL Application*		
Project Name/Number:	*2013 NB21 EWL Application/213-555*		

Disposition

Disposition Date: 09/14/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Employee’s Whole Life Application		Yes

SERFF Tracking #:	*NYLC-128681039*	***State Tracking #:***		***Company Tracking #:***	*213-555*

State:	*Arkansas*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*2013 NB21 EWL Application*		
Project Name/Number:	*2013 NB21 EWL Application/213-555*		

Form Schedule

Lead Form Number: 213-555

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		213-555	AEF	Employee's Whole Life Application	Revised: Replaced Form #: 212-555 Previous Filing #: NYLC-128159260	50.000	213-555 Final For Filing.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

EWLPART1 01

INDIVIDUAL LIFE INSURANCE APPLICATION TO:

NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, N.Y. 10010

☐ New Application ☐ Amend App Dated _____ ☐ Change/Reinstatement Policy No._____

A. Primary Insured

First Name | Middle Name | Last Name | Suffix | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip | Telephone Number ( )

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Driver's License No. | State | ☐ None (Provide details in Section J)

Country of Citizenship | Country of Birth | State of Birth | How Long Living in the USA? ☐ Since Birth **or** _____Years _____Months

Immigration Visa or Work Authorization *(If other than a US citizen)* Type | Number | Expiration: Month | Year | **Occupation**

Primary Insured's Email Address | Employee's Email Address (If not Primary Insured)

Date Employee Employed: Mo _____ Day _____ Yr _____

Has Employee purchased a guaranteed issue policy in the last 3 years? ☐ Yes ☐ No

If Primary Insured is under age 14 years 6 months, complete this section.

Amount of insurance in-force on the Applicant: $_____ ☐ None

Are all other children in the family insured or to be insured for an amount at least equal to that on the Primary Insured? ☐ Yes ☐ No (If "No", provide details in Section J)

B. Owner *(Employee/Member will be Owner unless otherwise indicated, if not Primary Insured)*

For all ownership types, name, address, and tax identification information is required.

☐ Same as Primary Insured

Type: ☐ Individual ☐ Trust ☐ UTMA/UGMA (Provide Custodian's information below)

Owner/Custodian First Name | Middle Name | Last Name | Suffix | ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

Telephone Number ( ) | Email Address | ☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for

Relationship to Primary Insured | Country of Citizenship

Immigration Visa or Work Authorization *(If other than a US citizen)* Type | Number | Expiration: Month | Year

Successor Owner ☐ Primary Insured First Name | Middle Name | Last Name | Suffix | Relationship to Primary Insured

C. Applicant

☐ Same as Primary Insured ☐ Same as Owner

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yyyy)

Residence: Street | City | State | Country | Zip

☐ Social Security No. or ☐ Tax ID No. ☐ Exempt ☐ Applied for | Relationship to Primary Insured

D. Primary Insured's Beneficiary

☐ Same as Owner

Named Beneficiaries (indicate class as 1st/Primary, 2nd/Secondary, etc.) ☐ Per Stirpes (Can only be checked if all beneficiaries are individuals)

Class	Full Name (First, Middle, Last)	Date of Birth	Social Security No./ Tax ID No.	Relationship to Primary Insured	Share
	Address & Phone # _____			☐ Same as Primary Insured	
	Address & Phone # _____			☐ Same as Primary Insured	
	Address & Phone # _____			☐ Same as Primary Insured	

E. Children's Insurance Information (CI)

If any child's address and/or phone # is different than the Primary Insured, provide details in Section J.

First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Relationship to Primary Insured	Social Security ☐ No. _____ ☐ Exempt ☐ Applied for
First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Relationship to Primary Insured	Social Security ☐ No. _____ ☐ Exempt ☐ Applied for
First Name	Middle Name	Last Name	☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Relationship to Primary Insured	Social Security ☐ No. _____ ☐ Exempt ☐ Applied for

CI Beneficiaries ☐ Owner/Standard ☐ Special Standard (List Owner's Spouse Info. Below) ☐ Primary Insured

Class	Full Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security No./ Tax ID No.	Relationship to Child Insured	Share
_____	_____	_____	_____	_____	_____

Address & Phone # _____ ☐ **Same as Primary Insured**

Class	Full Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security No./ Tax ID No.	Relationship to Child Insured	Share
_____	_____	_____	_____	_____	_____

Address & Phone # _____ ☐ **Same as Primary Insured**

F. Coverage Information

1. **Plan** ☐ Employee's Whole Life (EWL) ☐ Other_____ ☐ Automatic Premium Loan (APL)
2. **Riders** ☐ ADB (Accidental Death Benefit) ☐ WP (Waiver of Premium) ☐ LBR (Accelerated Benefits)
   ☐ OPP (Option to Purchase Paid-up Additions) ☐ OPP COM ☐ Schedule Bill $_____
   ☐ Unscheduled (Lump Sum) $_____
   ☐ CI (Children's Insurance) (_____ units) (Answer Section E) ☐ Other_____
3. **Divided Option** ☐ Paid-up Addn. ☐ Accumulation ☐ Premium ☐ Cash ☐ Other_____
4. **EWL Only Payroll Deduction Frequency for Arrangement**: ☐ Weekly ☐ Biweekly ☐ Semi Monthly ☐ Monthly
   Deduction Amt. $_____ **OR** Face Amt. $_____
5. **Payroll Deduction Authorization Completed** ☐ Yes ☐ No
   If "No" (applicable to accociations only), indicate amount of cash paid. $_____

G. Additional Information on anyone proposed for coverage on the policy

(Answer (a) for Employee only and (b) for spouse only and (c) for children or grandchildren only)

(a) During the last 3 months, has the Employee been actively and continuously at work on a full-time basis (at least 30 hours per week) except for vacations, normal non-working days, and other absences totaling not more than 5 days? .... ☐ Yes ☐ No

(b) During the last 3 months, has the spouse been able to continuously perform his or her daily activities or otherwise been actively and continuously at work on a full-time basis (at least 30 hours per week) except for vacations, normal non-working days, and other absences totaling not more than 5 days? ..... ☐ Yes ☐ No

(c) Based on a diagnosis or treatment by a licensed member of the medical profession, is each child or grandchild displaying physical and mental development that has not been impaired because of illness, injury or birth defect; and (1) if of school age and under age 16, regularly attending school; (2) if age 16 or older, regularly attending school or during the last 3 months, actively and continuously at work on a full time basis (at least 30 hours per week) except for vacations, normal non-working days, and other absences totaling not more than 5 days? ..... ☐ Yes ☐ No

Exclude any person from this form, for whom (a), (b) or (c) would be "No".

H. Personal Information (Answer the following only if Simplified Issue)

1. In the last 5 years, has the Primary Insured or any Additional Insured(s)

(a) had their driver's license suspended or revoked? ..... ☐ Yes ☐ No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below including reason, driver's license # (if other than previously stated), State of license, and month and year of occurrence.

Name	Reason	License #	State	Date (month/year)

(b) plead guilty to, or been convicted of any felony or misdemeanor, or are there any such charges currently pending?..... ☐ Yes ☐ No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below, including reason, State, County, and month and year of occurrence.

Name	Reason	State	County	Date (month/year)

2. In the last 12 months has the Primary Insured or any Additional Insured engaged in, or intend to engage in within the next 12 months, any of the following: ..... ☐ Yes ☐ No

If "Yes", check all that apply and complete Form Series 7663.

☐ SCUBA or skin diving; ☐ auto racing; ☐ motorcycle racing; ☐ power boat racing; ☐ snowmobile racing; ☐ all terrain vehicle (ATV) racing; or ☐ any other type of vehicle racing; ☐ sky diving; ☐ mountain climbing; ☐ helicopter skiing; ☐ cave exploration; ☐ hot air ballooning; ☐ rodeo riding; ☐ flying as civilian pilot; ☐ flying as a military pilot; ☐ ultralight?

3. Answer if Primary Insured is Employee's child or grandchild. Explain any "No" answer in Q. I.

(a) Is all insurance in force on Employee equal to at least twice Primary Insured's? ..... ☐ Yes ☐ No

(b) Will all children in family be insured for amounts equal to Primary Insured's? ..... ☐ Yes ☐ No

I. Medical Information (Answer the following only if Simplified Issue)

Answer the following, so far as known, for all persons named in Sections A and E. Use Section J for details of "Yes" answers. Include the names and addresses of medical professionals and list any prescriptions.

1 In the last ten (10) years, has any such person been diagnosed, treated, tested postive for or been given medical advice by a member of the medical profession for:

(a) heart disorder, angina, stroke, irregular pulse, elevated blood pressure, diabetes, cancer or tumor? ..... ☐ Yes ☐ No

(b) drug or alcohol use, used cocaine or other controlled substances (other than as prescibed by a physician), or been counseled or hospitalized for drug or alcohol use? ..... ☐ Yes ☐ No

(c) any psychiatric or mental health condition (including counseling or hospitalization)? ..... ☐ Yes ☐ No

2. In the last 2 years, has any such person been in a hospital or other medical facility (as a patient) for more than 5 days? ..... ☐ Yes ☐ No

3. In the last 2 years, has any such person been diagnosed or treated by a licensed member of the medical profession for:

(a) unexplained weight loss or swollen glands; recurring diarrhea, fever or infection; persistent cough, or pneumonia? ..... ☐ Yes ☐ No

(b) edema, transient visual loss, muscle weakness, disorder of back or spine, shortness of breath, or internal bleeding? ..... ☐ Yes ☐ No

(c) kidney, instestinal, blood, circulatory, or chronic respiratory disorder, liver or pancreas disorder, multiple sclerosis, epilepsy, seizures, mental retardation, memory loss or other neurological disorder? ..... ☐ Yes ☐ No

4. In the last ten (10) years, has the Primary Insured or any Additional Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)? ..... ☐ Yes ☐ No

5. **If age 18 or over, has Primary Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years?** ☐ Yes ☐ No

If "Yes", provide type _____and date of last use (Month)_____ (Year) _____

6. **What is Proposed Insured's:**

(a) Height:_____ ft _____in; Weight: _____ lbs.

J. Additional Details

Attach a separate sheet of paper if additional space is needed.
Please refer to each section letter when providing additional details and remarks.

Section

Statement of Agreement

Those Persons Who Sign This Application Agree That:

1. All of the statements, which are part of the application, are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's Incontestability Provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up New York Life Insurance Company's rights or requirements.
3. A limited amount of temporary coverage will be provided for up to 90 days, if the terms and conditions of the receipt are met. A signed Payroll Deduction Authorization or "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met. Temporary coverage is not provided if a policy or benefit is applied for under the terms of a conversion privilege or a guaranteed insurability option, or if reinstatement is applied for. Further, a reinstatement will not take effect until (a) the Insurer approves the application, and (b) the sum required by the Insurer with respect to the reinstatement application is paid during the lifetime of all persons to be covered under the reinstated policy.
4. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the Policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date.
5. By paying premiums on a basis more frequently than annually, that is monthly, quarterly, semi-annually, NYL-A-Plan, or by Check-O-Matic, the total premium paid during one year's time will be greater than if the premium were paid once each year, or annually. In other words, the cost of paying annualized periodic payments will be more than the cost of paying one annual premium.
6. WARNING: The arrangement of a sale, transfer or assignment of this policy, prior to or within a period of time specified by state law after the date the policy was issued, to a third party, such as a viatical settlement entity, a life settlement entity, other secondary market provider or premium financing entity, may violate the law of your state of residence. If there are any questions pertaining to these matters please consult with your legal advisor.

Fraud Warnings:

FOR ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Illustration

Do not complete this section if:
1. A signed illustration is not required by law; or 2. An illustration was signed and matches the policy applied for.

I, the Applicant, did not sign an illustration because:

☐ An illustration was not shown or given to me.

☐ An illustration was shown or given to me, but the policy applied for is different from the illustration.

☐ An illustration was displayed to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished. The illustration on the screen included the following personal and policy information:

Type of Policy _____ Proposed Insured _____

Initial Death Benefit _____ Rating/Class _____

Dividend Option _____ Age _____ Gender _____

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

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Statement of Agreement

Those Persons Who Sign This Application Agree That:

1. All of the statements, which are part of the application, are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's Incontestability Provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up New York Life Insurance Company's rights or requirements.
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4. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the Policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date.
5. By paying premiums on a basis more frequently than annually, that is monthly, quarterly, semi-annually, NYL-A-Plan, or by Check-O-Matic, the total premium paid during one year's time will be greater than if the premium were paid once each year, or annually. In other words, the cost of paying annualized periodic payments will be more than the cost of paying one annual premium.
6. WARNING: The arrangement of a sale, transfer or assignment of this policy, prior to or within a period of time specified by state law after the date the policy was issued, to a third party, such as a viatical settlement entity, a life settlement entity, other secondary market provider or premium financing entity, may violate the law of your state of residence. If there are any questions pertaining to these matters please consult with your legal advisor.

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Initial Death Benefit _____ Rating/Class _____

Dividend Option _____ Age _____ Gender _____

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.

Tax Certification

Under penalties of perjury, I (as the Owner named in Section A or B) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section A or B) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding.) and (3) I am a U.S. person (including a U.S. resident alien).

ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company obtains and uses data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the Authorization below.

AUTHORIZATION

In this Authorization, "I", "my" and "me" mean the Proposed Insured, "the Insurer" means New York Life Insurance Company and its respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by the Insurer, I authorize the following:

MEDICAL INFORMATION: Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB, Inc. may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

OTHER UNDERWRITING INFORMATION MIB, Inc., other insurance companies and consumer reporting agencies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; other applications for life insurance; and other policies of life insurance.

EXAMINATIONS AND TESTS The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

INVESTIGATIVE CONSUMER REPORT The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

RELEASE OF INFORMATION TO OTHERS The Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data, including a brief report of my protected health information and data about my life insurance policy (ies) Insurer issues on me, to MIB, Inc. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured. This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent the Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. _____ initial if requested).

The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

Signatures

By signing below, I/We understand that I/We acknowledge and agree to all of the statements and representations made in this application, including sections entitled Statement of Agreement, Illustration (if applicable), Check-O-Matic (if applicable), Tax Certification, Acknowledgement and Authorization. I/We accept and adopt as true all statements made by the Proposed Insured(s) in this application.

X _____
Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months)

Signed at _____ On _____
(City, State) (MM/DD/YYYY)

X _____
Signature of the Owner if Other than the Primary Insured

X _____
Signature of Applicant if Other than Primary Insured or Owner

X _____
Other Required Signature

X _____
Signature of Employee/Member (Applicant)

If Employee/Member (Applicant) is not the Proposed Insured, print Applicant's name, Soc. Sec. No. and indicate relationship to Prop. Insured. _____ ,
☐ Spouse; ☐ Parent; ☐ Grandparent

I Certify I have truly and accurately recorded all answers given to me.

X _____
Signature of Agent/Witness

X _____
Signature of Agent/Witness

X _____
Countersigned by Licensed Resident Agent *(if required)*

_____
Countersigned Code #

SERFF Tracking #:	*NYLC-128681039*	***State Tracking #:***		***Company Tracking #:***	*213-555*

State:	*Arkansas*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*2013 NB21 EWL Application*		
Project Name/Number:	*2013 NB21 EWL Application/213-555*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
213-555 Readability Cert.pdf			

NEW YORK LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

I certify that the form(s) listed on the attached page(s) meet the standards of your State's Readability Laws.

Flesch Scores for forms submitted with this filing are:

Form No.	**Flesch Score**
213-555	50.6

New York Life Insurance Company

Linda E LoPinto

Signature

Linda E. LoPinto
Name

Corporate Vice President
Title

September 11, 2012
Date